Abrams, A. The treatment of aortic aneurysms Edgar Cyclopaedia

and may be continued until the membranes are seen to protrude; the scalpel can then be laid aside, and the incision rapidly enlarged with scissors, or the whole incision may be completed by the scalpel; personally I prefer the former method. If the membranes are already ruptured, care must be taken that the fetus is not injured by the scalpel in making the uterine incision. In two cases I enlarged the incision by tearing with the fingers, and I found that the resulting wound presented no difficulties in suturing. When the incision is completed the membranes should be opened by scalpel or scissors and the fetus seized, preferably by the feet. If the placenta is encountered in the incision it should be rapidly separated by the fingers.

A most valuable manœuvre at this stage is for the assistant to hook up each end of the incision by passing an index finger into it during the extraction of the child; this prevents the uterus falling back into the abdomen as soon as it is emptied, and enables it to be readily brought out through the abdominal incision.

It is well to arrange beforehand that some one shall take charge of the child, otherwise, in the excitement of the moment, it may not receive proper attention. As soon as the child is removed the cord should be clamped in two places with long-bladed pressure forceps, and divided between; this saves time, and the tying can afterwards be done by the person to whom the care of the child is entrusted.

The placenta and membranes should be carefully detached and peeled off the uterine wall, and while this is being done the uterus should be enveloped in sterilized hot cloths, and gently kneaded to ensure contraction. This is usually sufficient to arrest haemorrhage, but if it continues, the assistant should grasp the broad ligament on each side with the finger and thumb whilst the operator continues to knead the uterus. Although the haemorrhage during the uterine incision and the extraction of the child looks very alarming, good contraction usually ensues as soon as the uterus is completely emptied and kneaded by the hand, and I have had no really dangerous haemorrhages in any of my cases.

We have now to decide the question of sterilization; it is particularly in cases of contracted pelvis that this question arises, for in cases such as my third, in which the cause of obstruction can be effectually removed, sterilization is, of course, not required. Even in cases of contracted pelvis many authorities are now opposed to sterilization, and several cases have been published in which Caesarean section has been repeated two or more times on the same patient.

This is a question in which the wishes of the parents should be allowed to have weight, and the prospects of the offspring from the eugenic point of view should be taken into consideration; this last point of view seems to have been entirely overlooked in a case operated on by Sir William Sinclair, and published in the *Journal of Obstetrics and Gynaecology of the British Empire*, January, 1904; the patient, who was extremely deformed by rickets and hip-joint disease, was of a low order of intelligence and had spent nearly all her life in workhouse infirmaries. Caesarean section was performed three times, a living child resulting on each occasion.

In my own cases the following course was pursued as regards sterilization:

In two of the cases, Nos. 3 and 7, the operation was performed for other conditions than contracted pelvis—in No. 3 for labour obstructed by a dermoid cyst; in this case sterilization was not performed, and the patient has since been delivered successfully of a live child, *per vias naturales*. In No. 7 labour was obstructed by a fibroid; the tumour was situated low down on the posterior uterine wall, and had a wide attachment, and, as myomectomy seemed inadvisable, supravaginal hysterectomy was performed.

This leaves eight cases of contracted pelvis. In two, the first and fifth on the list, supravaginal hysterectomy was performed, purely to obtain sterilization; in No. 2 the same operation, partly because there was evidence of commencing rupture of the uterus. Sterilization by excising a piece of each tube was performed in three cases, Nos. 4, 6, and 8, and in the last two cases, Nos. 9 and 10, no sterilization was performed.

The following methods of obtaining sterilization have to be considered: Oöphorectomy, hysterectomy, ligature of the Fallopian tube, excision of a piece of each Fallopian tube.

Oöphorectomy is not a method to be recommended. Hysterectomy is a method which has the approval of Mr. Bland-Sutton, but in the opinion of most operators it is too severe a proceeding when sterilization alone is aimed at. Tying the tubes has been proved to be quite ineffectual. Excision of a portion of each tube appears to be, on the whole, the method which is to be preferred and most in favour. I have met with a case in which pregnancy occurred in a patient who had undergone Caesarean section, with excision of a portion of each tube, in Queen Charlotte's Hospital eight years previously; and other cases have been recorded, though the instances must be very rare. Sterilization is made more certain if the uterine end of the tube is excised and the incision in the uterine wall closed by sutures.

Hysterectomy is indicated in cases in which there is reason to think that the uterus is already infected, or in which there is rupture of the uterus. If the operation is performed, the supravaginal amputation with intraperitoneal treatment of the stump should be considered the operation of selection.

For suturing the uterine wall I used silk in all my cases, except the last, in which I used chromic gut for the deeper sutures. I have not met with any ill result from the use of silk, and I prefer it to any other material. I have in every case sutured in two layers, the deeper one including the peritoneum and muscular wall, but not penetrating the mucous membrane, and the superficial layer taking peritoneum only and being applied in Lembert's fashion.

Drainage was not used in any of the cases. The abdominal wall was closed in layers in every case. The abdominal wound healed by first intention in all except one; the case which suppurated was No. 2, the case which had been longest in labour, and the only one in which prolonged attempts at forceps delivery had been made.

The danger of Caesarean section increases enormously with the length of time the patient has been in labour and the amount of manipulation she has undergone, and when performed on a patient who has been infected by septic hands or instruments, the death-rate is high, but in uninfected cases the operation gives most satisfactory results.

ON THE TREATMENT OF THE EXCESSIVE VOMITING OF PREGNANCY.

BY

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DURING my term of residence as senior house-surgeon in the Glasgow Maternity and Women's Hospital seventeen cases of the excessive vomiting of pregnancy or hyperemesis gravidarum were sent in for treatment, and in each case the diagnosis of the family doctor was confirmed by observations at the hospital.

All the patients before admission had for several weeks been treated with the usual "stomach drugs," and in two cases rectal feeding had been tried for some days without any improvement. One case was admitted very ill and died. On admission she could retain nutriment neither by the mouth nor the rectum. She was in that hopeless condition described by Dubois, "characterized by increased prostration, constant headache, impairment of vision, tendency to somnolence, and derangement of the intellectual faculties. To operate in these circumstances would only bring obloquy on our art and perhaps hasten the patient's end."

On referring to textbooks regarding the treatment of this distressing complication of pregnancy, one is struck by the number and variety of drugs that are all strongly recommended. I doubted the efficacy of this drugging, and it seemed to me that other treatment should be adopted.

On admission the patient's history was carefully gone into. A thorough examination of all the symptoms was made, particular attention being paid to the condition of the alimentary canal, vagina, uterus, and appendages.

In view of the recent writings on appendix dyspepsia, this point was investigated, but the result was negative in all. Bad teeth and chronic constipation were found associated in every case.

The patient was strictly confined to bed, and was assured

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that her disorder was only temporary, and that under treatment she would entirely recover. By means of the stomach tube the stomach was washed out thoroughly with warm water at a temperature of 100° F. No alkali was used in the washing, as I did not wish in any way to disturb the gastric secretions until I had examined the result from the test meal. In every case the large quantity of mucus obtained was surprising. Sips of cold water were allowed that night, and an enema of soap and water (ʒxxx) was administered. A test meal was given next morning, and withdrawn one hour after by the stomach tube. In no case was the test meal returned, and in one patient no vestige of the test meal was obtained even by again washing out the stomach.

The filtrate from the test meal was examined, free HCl was present in every case, and, except in three patients, the free HCl and total acidity were normal; in these three exceptions the free HCl and total acidity were slightly below normal. The motor activity of the stomach was tested in five cases by the salol method and was found normal. Microscopic examination proved negative, and the reaction for lactic acid was never present.

I therefore came to the conclusion that the drugs bismuth carbonate, cerium oxalate, etc., recommended in textbooks were not required for these 16 cases of hyperemesis gravidarum. For several days the patients were put on peptonized milk and milk and soda, and were thereafter given light diet. No hard and fast rule was laid down as to the day of treatment on which the patient was advanced to a light or a full diet; each case was considered separately and dieted accordingly. The patients were not allowed up until they had been on light diet for two days. A powder containing 1 grain of mercury-with-chalk powder and 3 of sodium bicarbonate was given thrice daily. For chronic constipation, in conjunction with the above powder I found magnesium sulphate in hot water every second morning the best aperient. If a satisfactory motion was not obtained, then a soap and water enema (ʒxxx) was given. The septic condition of the mouth was treated with a mouth wash of carbolic acid solution 1 in 80, used frequently and always immediately before and immediately after food. The patients were encouraged to drink copiously of milk and soda, weak tea, and imperial drink.

This treatment was quite successful in the 16 cases, the average duration of residence in the hospital being seventeen days. One patient was treated in hospital for about ten days with the textbook drugs without improvement. She was then treated as above and at once improved. She was dismissed well within three weeks thereafter. She had no return of vomiting, went to full term, and was delivered of a healthy child. In another case there was retroversion of the uterus with tendency to prolapse; the uterus was not interfered with, and she made a complete recovery. Five cases presented a well marked acetone odour. Several cases returned to hospital at full time in labour, and had had no return of the vomiting.

A point worthy of notice is that 15 of these cases were admitted to hospital during the months of November and December, 1909, and January and February, 1910. The weather in Glasgow and neighbourhood during the first three months mentioned was extremely inclement, and did not conduce to out-of-door exercise. The continuance of fog and excessive cold was such that the death-rate in the city was on several occasions over 30 per 1,000 a week. With improved weather 2 cases only were sent into hospital from March 1st to May 31st, 1910. I am of opinion that in hyperemesis gravidarum, as in eclampsia, prophylactic treatment is of prime importance, and recommend the following as the important points:

1. Bowels to be moved at least once per diem.
2. Prevention of oral sepsis.
3. Good plain well-cooked food, daintily served at regular hours.
4. Kidneys and skin to be kept active.
5. Gentle exercise in the open air daily if weather at all suitable, and a good supply of fresh air night and day.

Summary of treatment when hyperemesis gravidarum has developed:

1. Wash out the stomach.
2. Bowels, kidneys, and skin to be kept active.
3. Nutriment at regular hours.
4. Fresh air night and day.

THE TREATMENT OF AORTIC ANEURYSMS.

BY

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Aortic Reflexes.

In 1904[1] I demonstrated that, if one made forcible concussion of the seventh cervical spine, the normal aorta could be brought to contraction (aortic reflex of contraction), and that, if the last four dorsal vertebral spines were struck a series of sharp vigorous blows, a dilatation of the aorta (aortic reflex of dilatation) ensued. A like response was observed in aortic aneurysms.

It occurred to me that the aortic reflex of contraction could be utilized in the treatment of aortic aneurysms. Forty cases of aneurysm of the thoracic and abdominal aorta have thus far been treated, and have all been symptomatically cured in a brief period of time. Some of the patients were seen after a period of four years with absolutely no recurrence of symptoms.

I desire to emphasize the following facts:

1. Aneurysm was only diagnosed when the classic symptoms of the disease could be demonstrated by physical and skiascopic methods of examination.

2. Pressure symptoms were present and the disease was in an advanced stage in all the patients.

3. The only treatment employed was concussion of the seventh cervical spine. Not even rest was enjoined, although the patients were instructed to avoid straining at stool and exertion.

In the therapeutic elicitation of the aortic reflex of contraction an apparatus which gives a percussion stroke must be employed; all other motions, such as oscillations, shaking, and friction, interfere with results. The pad of the apparatus can be applied directly to the seventh cervical spine, or indirectly if the skin is sensitive, by interposing a piece of lint or linoleum. The daily sittings of concussion last about fifteen minutes, but the treatment must be interrupted to avoid irritation of the skin. If a suitable apparatus is not available, a pleximeter of rubber, wood, ivory, or linoleum is applied to the seventh cervical spine and struck a series of rapid and moderate blows by means of a strong percussion hammer. I use the plexor of Déjerine.*

The subsidiary centre of the vaso-constrictor nerves of the aorta is in the spinal cord, in proximity to the spinous process of the seventh cervical vertebra (third dorsal segment of the spinal cord); and by stimulation of this centre by concussion the normal as well as the abnormal aorta may be brought to contraction. Other stimuli have been tried, but the most effective stimulant to elicit the reflex is concussion. The aortic reflexes are mediated through the vagus; they are accentuated after a hypodermic injection of pilocarpin (0.0065 gram) and inhibited by atropin (0.001 gram).

To illustrate the rapidity of results achieved by this method, three cases will be cited:

Patient of Dr. L. St. John Hely.[2]—Aneurysmal tumour which protruded from the chest measured 2½ in. in diameter at the base. After the fourth treatment there was an absolute disappearance of all symptoms (incessant dyspnoea, cyanosis, choking, cough). At the end of a week the size of the tumour was reduced 25 per cent., and further treatment was discontinued, insomuch as the patient regarded himself as cured. This patient was observed after fourteen months with no return of subjective symptoms.

Patient of Dr. Hubert N. Rowell.—Pronounced pressure symptoms. Before treatment could not get more than three hours' sleep at night, owing to paroxysmal attacks of coughing and choking. After the first treatment he could sleep the entire night, and after two weeks' treatment the patient was practically well, and had gained 10 lb. in weight. This patient was seen after three years, with absolutely no return of symptoms.

Patient of Dr. Wm. Clark.—In addition to the conventional objective signs of aneurysm, there was a pronounced exophthalmos. The subjective signs were dyspnoea, incessant cough, dysphonia, and the patient was subjectively conscious of the aortic bruit. All the subjective symptoms disappeared within several days after treatment was commenced, and after five weeks' treatment the patient was practically discharged. After a lapse of more than two years the patient is absolutely well.

*The method of treatment is discussed in detail in the author's book, *Spondylotherapy*, 1910, Philopolis Press, San Francisco.

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CONCLUSIONS.

1. Elicitation of the aortic reflexes aid the diagnosis of aortic aneurysm.

2. Elicitation of the aortic reflex of contraction results in the symptomatic cure of aortic aneurysms, and the results are so astonishingly rapid that one is warranted in concluding that the method is practically a specific.

3. If results are not achieved, there is either an error in diagnosis or the aneurysm is beyond restitution.

4. By aid of skiascopy, skiagraphy, percussion, and auscultation one may determine objectively the improvement of the patient, although the reduction in the area of the aneurysmal tumour is not in proportion to the amelioration of the subjective symptoms.

5. It is reasonable to assume that like results may be achieved in aneurysms of other vessels, insomuch as plethysmography, sphygmography, and other observations by the author show that all the arteries of the body are brought to contraction by definite stimuli applied to the seventh cervical spine.

REFERENCES.
[1] Abrams, *American Medicine*, April 2nd, 1904; *Medical Record*, September 16th, 1905. [2] Abrams's Method in the Treatment of Aneurysm of the Aorta, *Medical Record*, May 21st, 1910.

HYPERTROPHIED PAPILLAE OF MORGAGNI CAUSING RECTAL SYMPTOMS.

BY

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THE papillae of Morgagni are situated at the ano-rectal junction, and though absent in the majority, are yet present in a considerable proportion of individuals. They are normally small white glistening papillae, pyramidal or triangular, with the apices directed upwards and inwards towards the lumen of the gut. In number they vary from one to six, and are situated either at the upper extremities of the columns of Morgagni or on the edges of the valves intervening between the upper ends of these columns. Their length varies from $\frac{1}{8}$ in. to $\frac{1}{3}$ in.

Stroud[1] describes them as consisting of myelinated and non-myelinated nerve fibres, with a considerable number of ganglion cells and very little connective tissue. They are covered by a stratified epithelium.

When hypertrophied, the papillae much resemble in shape and size the writing end of an ordinary lead pencil. They must be distinguished from the small fibrous polyp which sometimes forms on the top of an internal haemorrhoid.

Stroud has shown that these papillae are peculiar to man, occurring at all periods of life, having been seen in the fetus, and in patients of advanced years. They are not found in the lower animals, though search has been made for them. They are considered to be accessory sense organs, aiding and warning the anal sphincters. When these functions become unduly developed and the papillae are hyperaesthetic, they give rise to symptoms. Andrews[2] speaks of them as "special sense organs of the rectum," and mentions their removal as one of the causes of incontinence which sometimes occurs subsequent to Whitehead's operation for haemorrhoids.

While realizing that the out-patient department of a rectal hospital is not the place to investigate the normal rectum, I have examined fifty patients with the speculum, as far as possible in consecutive order. In this series papillae were present in nineteen instances, or 38 per cent. of the cases. The age of the patients examined ranged from 12 to 68 years with an average of 39 years, and the average age of those in whom papillae were present was 38 years. The number of papillae varied from one to six with an average of two.

The symptoms attributable to the hypertrophied papillae are as follows:

1. *Irritation.*

This is by far the most frequent cause of complaint, and in a large percentage of patients suffering from pruritus ani these hypertrophied papillae greatly augment the trouble, if indeed they are not the sole cause. This is demonstrated by the beneficial effect of cauterization or removal, as in practically all cases the patients are greatly relieved and many cured. In a series of 53 patients suffering from pruritus ani attending the out-patient department of St. Mark's during the six months June to November, 1910, hypertrophied papillae were present in 13 cases—that is, in 25.6 per cent.

The papillae were cauterized more or less thoroughly in all these cases, and in only one was there lack of improvement. The majority of cases made two subsequent attendances, reporting great relief, and then ceased to attend. One case of a Jewess was particularly marked. She had irritation of eight months' duration; she had the typical hard plicated skin surrounding the anus common in people who suffer from irritation. Two papillae were cauterized, and from that time the irritation ceased, and a month later she had suffered no return, and discharged herself cured. It has yet to be proved whether this benefit is to be permanent.

2. *Pain.*

During the same six months I have collected 12 cases in which the complaint was of (*a*) pain in the lower part of the back, aching in character; (*b*) shooting pain in the rectum; (*c*) intense pain when the bowels acted, differing from that produced by fissure or fistula in that, instead of a sharp burning or stabbing pain of considerable duration, it is a sensation of sharp pricking which soon passes off. Careful examination in all these cases revealed nothing except hypertrophied papillae.

In every case cauterization afforded relief. Of the three types of pain mentioned, the shooting pain in the rectum, extending up to the base of the spine, is the most usual, while the dull aching pain and that present when the bowels act seem to be about equal in frequency.

3. *Sensation of Mass in the Rectum.*

This is a very common symptom, and, as a rule, the patient says that he feels as though the bowel protrudes on defaecation, but that nothing actually emerges. In these cases, again, the symptoms disappear on cauterization of the papillae. In all these 12 cases the patients complained of pain of one of the three types above mentioned, and also of the sensation of a lump in the rectum.

When much hypertrophied the papillae can be readily recognized by digital examination as small, shotty nodules. They can always be seen at the ano-rectal junction by means of a speculum.

Treatment.

Cauterization is undoubtedly the simplest, quickest, and most effective method of destroying the papillae; other methods I have tried, such as snipping off with scissors and destruction with nitric acid and other caustics, have no advantages, and are not so complete. The pain attendant upon cauterization is slight, and may be abolished by insufflating some analgesic powder through a speculum and allowing it to remain in the rectum for ten or fifteen minutes, after which cauterization is absolutely painless. The method used at St. Mark's Hospital is to pass a Kelly's speculum into the rectum and then withdraw it until the papillae stand up at the inner end, when they can be successively touched with the electric thermocautery. One application is generally sufficient, but in three cases I have recauterized two weeks later.

It is remarkable that none of the works on rectal surgery gives any attention to the symptoms caused by these papillae. They were mentioned as a separate disease in the annual report of St. Mark's Hospital for the first time in 1908, when eleven cases were treated as in-patients.

In one book of rectal surgery[3] only are they mentioned, near the end of a long list of causes of pruritus, but I have been unable to find any mention of them in connexion with other symptoms.

I am much indebted to Messrs. Mummery, Baldwin, and Gordon Watson, the surgeons in charge of the out-patients, for their kindness in allowing me to use their cases, and particularly to Mr. Gordon Watson for his suggestion that I should collect these cases, and for the assistance he has given in these investigations.

REFERENCES.
[1] Anatomy of Anus, *Annals of Sugery*, July, 1896, by B. B. Stroud of Cornell University, U.S.A. [2] *Surgery of Rectum*, Andrews, p. 303. [3] *Diseases of the Rectum*, Allingham, p. 240.

Memoranda:

MEDICAL, SURGICAL, OBSTETRICAL.

GASTRO-INTESTINAL HAEMORRHAGE IN A NEWBORN INFANT.

I WAS much interested in reading in the JOURNAL of April 29th the report of Dr. Mills's case of gastro-intestinal haemorrhage (melaena neonatorum), having seen a similar case two days before, though, I am happy to say, the result was more fortunate. The symptoms were almost identical, the haemorrhage coming on thirty-six hours after birth; the labour was normal (second confinement), and not unduly delayed—there was no interference. The parents were healthy. After birth the child took the breast well, but thirty-six hours afterwards began to vomit bright blood, and also pass blood and clots very frequently from the bowel. It became very blanched with very cold extremities, and appeared to be dying of collapse. Brandy was rubbed on the gums. She was kept quiet and warm, and gradually revived. In twelve hours she was sleeping comfortably, her colour was better, and she began to take the breast again; the motions after twenty-four hours were again normal, and without any trace of blood, and vomiting had not recurred. The interest of this case is chiefly in the rarity of the disease, and in the recovery of the child, the mortality in these cases being about 60 per per cent. What was particularly remarkable was the enormous quantity of blood passed (fifteen cloths saturated) and the quick recovery after such a loss. There were no symptoms of ulcer of stomach, or duodenum, before or after the haemorrhage, and it was too sudden for capillary oozing. One must attribute the cause to embolism of the umbilical vein near the liver, extending into its branches for some distance (Landau). There was no evidence that the blood came from the mother's breast; there was no jaundice.

Budleigh Salterton. HENRY F. SEMPLE.

SEVERE INJURY OF HAND: OPERATION: RESULT.

THE following case seems worth recording, both on account of the unusual nature of the injury and because of the result of treatment, in circumstances which at first did not appear very promising.

The patient, a farm labourer, aged 25, was admitted to the Leominster Cottage Hospital on December 28th, 1910, having had his right hand caught in a truss binder.

State on Examination.—There was a lacerated transverse wound on the dorsum of the hand. A comminuted fracture of the index-metacarpal bone was also present. Hanging free out of the wound were the whole lengths of the extensor tendons of the index and middle fingers, a small portion of its muscular belly being attached to each tendon. The machinery had evidently gripped the tendons on the dorsum of the hand, and the "drag" had caused them to rupture high up in the forearm, and to be pulled downwards in their sheaths, and out at the wound.

Treatment.—Under an anaesthetic the wound was thoroughly cleansed. A loose fragment of the index-metacarpal was removed. Reposition, *in situ*, of the tendons was out of the question, owing to their lacerated and dirty condition. They were therefore cut off short, about the level of the wrist. An incision was then made upwards for about 4 inches from the middle of the wound, skin flaps were reflected, and the extensor of the ring finger exposed. The distal cut end of the middle finger tendon was then stitched into a short longitudinal slit in the ring finger tendon. The communis tendon of the index was fixed to the ring tendon rather higher up. Lastly, the extensor indicis tendon was sutured into a slit in the side of the middle finger extensor. Catgut sutures were used. The open sheath of the ring tendon was sutured, and the skin wounds closed, a small tube drain being inserted in the lower wound. A palmar splint was applied, fixing fingers and wrist in a position of hyperextension.

Result.—Passive movement was begun in about a week, and active movements shortly afterwards. The splint was removed in three weeks. The hand wound had of necessity to heal partially by granulation. The patient left hospital on January 30th, 1911. In the middle of April there was almost perfect power of extension of the index and middle fingers, in spite of the scar being rather adherent. The fracture of the index-metacarpal was also firmly consolidated.

In view of the septicity of the wound, and the possibility of adhesions it was thought unwise to suture the index tendons to the extensor longus pollicis tendon (and thus perhaps compromise the movements of the thumb), though this would have been a simpler procedure than was adopted. During a rather long experience of casualty work at the Leeds General Infirmary I do not recollect a similar case, and for this reason thought it of sufficient interest to record.

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Late Casualty Officer, Leeds General Infirmary.

PEPPERMINT OIL IN CORYZA.

IN the EPITOME OF CURRENT MEDICAL LITERATURE of June 10th Dr. Laurens's conclusions on the use of menthol in coryza, rhinitis, etc., are given, in which he says he considers that menthol is a valuable remedy in such diseases, but that it has fallen into disrepute owing to its irritating effects on the mucous membrane.

I was much interested in this, as I have been trying oleum menthae piperitae instead of menthol for coryza, and have had extremely good results from the treatment.

The first case I used it in (two and a half years ago) was one of cold in the head with severe headache from pressure in the frontal sinuses, and my chief object was to try if possible to relieve the headache. Both nostrils were occluded by swelling of the mucous membrane, and a clear watery discharge was constantly running from the nose. I put a few drops of peppermint oil in a saucer, and heated it over a candle till the fumes rose, and got the patient to try to breathe this up her nose. This inhalation was kept up continuously till there was a clear passage through both nostrils, and shortly after this occurred she had a feeling as if something broke in her head, a few drops of fluid came down her nose, and the headache disappeared. This result was so much better than I had expected that I made her continue inhaling the fumes for a couple of hours longer, and I also added a few drops of Jeyes' fluid, as I thought it would be a useful antiseptic when volatilized. I told her when the saucer became nearly dry to add a few drops more of both, and continue the heating, so that fumes might be pretty continuously inhaled. The patient went to sleep that night with her nose free and headache gone, and woke next morning with no signs of a cold. I might mention that the treatment was started about 6 or 7 p.m., and stopped, I should think, between 10 and 11 p.m.

I have not tried whether in other cases cure would be as quick, but have made patients continue the treatment longer, and in the early stages of colds with congested mucous membrane and watery discharge I have found it very successful. Unless too strong a sniff is taken after the passages are opened, peppermint oil volatilized in this way does not cause discomfort.

The essential part of the treatment is to continue it after the nose has become clear, and not to allow the passage for air to become obstructed again for some hours.

London, N. RONALD T. HERDMAN, M.D.

LATE CONCEALED *POST-PARTUM* HAEMORRHAGE.

MRS. A., aged 31, was confined of her eighth child on April 5th, 1911. She was attended by a midwife. Nothing abnormal noted during the puerperium or at labour. She got up on the tenth day, and went out for the first time on April 26th. She was taken suddenly ill in the street, and had to be brought home in a cab in a state of collapse. When first seen by me she was pallid and pulseless and the extremities were cold. She made no complaint of pain in the abdomen, and there was no external haemorrhage. The uterus, enlarged and soft, reached to the level of the umbilicus. I was at a loss to account for this. Raising the legs, hot applications to the abdomen, and sipping hot water—the friends had given her about 3 oz. of brandy—revived her temporarily. I had to leave, but gave orders not to move her off the couch on which she was lying for at least an hour. She felt so much better, however, that she begged to be taken upstairs to bed; the friends did this about fifteen minutes after I had left. When I saw her fifteen minutes later she was in bed in a moribund state. She died in about ten minutes.

A limited *post-mortem* examination was made. The distended uterus was full of dark blood clot.

The case is one of a kind not mentioned in the text-books I have consulted. Firm kneading of the uterus had